TO: SIM Program Office
FROM: Planned Parenthood of Southern New England
RE: Comments on Draft CCIP Report

Thank you for the opportunity to comment on this draft report which clearly represents an enormous amount of time and commitment by a variety of individuals and organizations. As a trusted women's health care provider and advocate, Planned Parenthood Southern New England ("Planned Parenthood") supports the Practice Transformation Task Force's ("Task Force") efforts to develop strong standards for the Clinically and Community Integrated Program (CCIP), which aims to enhance health care quality, close health equity gaps, and improve the overall health care experience for diverse populations.

Planned Parenthood of Southern New England is Connecticut's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the state. Each year, Planned Parenthood's 17 health centers in Connecticut provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted diseases (STDs), and other essential care to about 64,000 patients. Our health centers routinely provide basic preventive care, including cervical cancer screening, breast exams, Chlamydia testing, HIV testing and counseling, body mass index (BMI) screenings, blood pressure assessments, and tobacco use screening and counseling services. We also provide abortion services and ensure that women have accurate information about all of their reproductive health care options. The majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level ("FPL").

As the CCIP standards are refined, we recommend that the Task Force consider the important role that other providers, beyond Federally-Qualified Health Centers (FQHCs) and Advanced Networks, can play in addressing the health care needs of men and women in Connecticut. These providers, including reproductive health care providers OB/GYN providers, can meet many of the CCIP standards and are poised to serve a larger role in statewide transformation efforts as trusted providers in their communities. However, the proposed Medicaid Quality Improvement and Shared Savings Program (MQISSP) to which the CCIP standards will be applied unfortunately does not contemplate these providers participating in SIM-funded technical assistance. Furthermore, the standards, as written, do not adequately address the role these providers play in improving health and wellness in the state.

Recognizing that the Task Force has asked for comments on specific standards, below we have noted specific standards that could be altered to ensure women's health care needs can be more prominently addressed in the CCIP:

- Health Equity: Continuous Quality Improvement Standards
- Target Population: Individuals Experiencing Equity Gaps Intervention Standards
- Integrating Behavioral Health Standards

Health Equity

We appreciate the Task Force's commitment to addressing and reducing health disparities across the reformed health care system. However, we see an opportunity for the Task Force to explicitly call out women of color as a pre-defined sub-population group (on page 37 of the draft report) so that this important health equity goal can be fully realized. By not specifically referring to the women's experience with health disparities, the proposed standards discount the fact that gender can combine with race and ethnicity to result in significant health care disparities for women. Women of color often experience worse health outcomes – especially reproductive health outcomes – due to entrenched barriers to health care

access. For example, diabetes is 60% more common in African-Americans than in white Americans; African-Americans are three times more likely to die of asthma, and for African-American women, in particular, more than 45 percent have high blood pressure. Additionally, African-American women are more than five times as likely as non-Hispanic white women to be diagnosed with sexually-transmitted infections (STIs), including HIV.[1] Latina women are more likely to be diagnosed with cervical cancer than women of any other racial or ethnic group.[2] These health disparities have lasting effects on women of color and their children. Because of insufficient health care access before and during pregnancy, women of color are much more likely to experience worse birth outcomes. In fact, Connecticut's infant mortality rate for African-American infants was nearly three times higher than the rate for white infants in 2011-2013.[3] As the Task Force builds out their plan for addressing health inequities, it is essential that the group sets out a deliberate approach for ensuring that the needs of women of color are met – and health inequity experiences are addressed – in clinically-integrated models.

- Because women of color often experience unique health disparities, we recommend that the Task Force identifies women of color as an explicit sub-population group in these health equity standards.

Many women of color consider their OB/GYN provider to be an essential part of their health care. In fact, Latinas are far more likely (47 percent) to say their OB/GYN provider is their main source of care, compared to 35 percent of women overall. 64 percent of African-American women say they see an OB/GYN provider regularly, compared to 58 percent of women overall.[4]

- With this in mind, we recommend that the CCIP standards further consider links with other providers, including OB/GYNs, to participate as valued members of clinically-integrated models so that women of color do not lose a trusted access point to the broader health care system.

Individuals Experiencing Equity Gaps

We commend the Task Force for promoting culturally and linguistically appropriate health care and seeking to standardize care processes so that those goals are achieved. We understand how vital culturally and linguistically appropriate health care is, especially when it comes to reproductive health – which can sometimes be a sensitive conversation topic. At PPSNE we have long offered medical interpretation to our patients, and adhere to CLAS standards, to make certain that the patient is autonomously receiving health information and the informed consent she needs to make her own decisions.

- As part of your High Level Equity Gap Intervention Design, CHWs should require specific training in order to understand and value reproductive health care and to attend to patient needs with information and without bias.

PPSNE trains professionals and parents about the sexual health needs of developmentally delayed individuals, who (as they mature) will fall into the behavioral health "complex case" target

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[1]Centers for Disease Control and Prevention, "Health Disparities in HIV/AIDS, Viral Hepatitis, STDs, and TB," March 2014. http://www.cdc.gov/nchhstp/healthdisparities/africanamericans.html

[2] Centers for Disease Control and Prevention, "Cervical Cancer Rates by Race and Ethnicity," August 2015 http://www.cdc.gov/cancer/cervical/statistics/race.htm

[3] Matthews, TJ et al, "Infant Mortality Statistics from the 2013 Period Linked Birth/Infant Death Data Set," Centers for Disease Control, National Vital Statistics Reports, Vol 64 No 9, August 2015. http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf

[4] Perry Undem Research & Communication, "Women & OB/GYN providers," *Planned Parenthood Federation of America*, November 2013. http://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.

population. Your intervention design must equip professionals with enough information about reproductive health and healthy sexuality to provide (in your words) "culturally sensitive medical education about their condition, behavior change education to promote a healthy life style and identifying and connecting the individual to needed support services."

Integrating Behavioral Health

We were pleased to see the Task Force concentrate on ensuring behavioral health screening and services are well-integrated in broader health care service delivery. We encourage the Task Force to consider allowing additional providers to play a role in identification of behavioral health issues and referring patients, as needed, to behavioral health professionals. For example, the PHQ-2 and PHQ-9 surveys can be administered at several points of access—not only just FQHCs and Advanced Networks. Moreover, women trust OB/GYN providers more than other providers,[5] so there is a strong relationship that can serve as a jumping off point for ensuring patients are able to get the behavioral health care they need.

- For maximum impact, the CCIP standards should recognize and value that these critical behavioral health screenings and referrals may be performed by other providers, including OB/GYNs.

Thank you for this opportunity to comment on the draft document, and we welcome any questions you may have about them.

Sincerely,

Judy Tabar, President & CEO
Planned Parenthood of Southern New England

[5] Perry Undem Research & Communication, "Women & OB/GYN providers," *Planned Parenthood Federation of America*, November 2013 http://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.